Date Received in DHHS Office:

For DHHS use only

Application for Medicare Part B Premium Assistance for Qualifying Individuals (QI)

1. TELL US ABOUT YOURSELF (THE PERSON APPLYING FOR HELP IN PAYING THE MEDICARE PREMIUM)

Name (First, Middle Initial, Last):	**Social Security Number**:	**Medicare Number:**	**Date of Birth**:

Address where you get mail (include apartment number) **City** **State** **Zip Code**	**County**:
Home Address (if not the same as your mailing address) **City** **State** **Zip Code**	**Telephone Number**: ( )

Sex:	**Marital Status**:	**What language do you use most?**	**Race**	
☐ Female ☐ Male	☐ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced	☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Sign Language ☐ Vietnamese ☐ Other:	**Race**	☐ White/Caucasian ☐ Black/African American ☐Multi Race ☐ Federally Recognized Native American (Must give proof of tribe membership) ☐ Other Native American ☐ Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other/Unknown ☐Hispanic

2. IF YOU ARE MARRIED AND LIVING TOGETHER, TELL US ABOUT YOUR SPOUSE

Name (First, Middle Initial, Last):	**Social Security Number**:	**Medicare Number:**	**Date of Birth**:

Sex:	**Race**	
☐Female ☐ Male	**Race**	☐ White/Caucasian ☐ Black/African American ☐Multi Race ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Federally Recognized Native American (Must give proof of tribe membership) ☐ Other Native American ☐ Alaska Native ☐ Other/Unknown ☐Hispanic

3. IF YOUR CHILD UNDER 22 LIVES WITH YOU, GIVE US THIS INFORMATION.

Child's Name	Birth Date	Social Security Number *(Optional)*	Child's Income	How often received?

4. LIST ANY INCOME YOU OR YOUR SPOUSE HAVE FROM ANY SOURCES LISTED BELOW.

Income Source	Yourself		Spouse	
	How Much?	How often received	How Much?	How often received
Social Security				
Veteran's Benefits: *Please send in copy of award letter from V.A.*				
Employment: *Please send in copies of pay stubs for the four weeks prior to the date you signed the application*				
Annuity or retirement fund: *Please provide copy of most recent pay stub or letter verifying gross monthly pension amount*				
Money from friends or relatives		☐Weekly ☐Monthly ☐Quarterly ☐Yearly		☐Weekly ☐Monthly ☐Quarterly ☐Yearly
Self employment income: *Please provide copies of most recent years tax returns, including all schedules*				
Income from a Trust: *Please send in copy of trust*				

5. DOES THE EQUITY VALUE OF ALL YOUR ASSETS ADD UP TO MORE THAN $6,940 IF YOU ARE SINGLE, OR $10,410 IF YOU ARE MARRIED AND LIVING WITH YOUR SPOUSE?

Assets are things that you own, such as cars, boats, trailers, non-homestead property, checking and savings accounts, cash, and CDs. Equity value is how much something is worth minus any money owed on it. (For example, if you have a vehicle that is valued at $5,000 and you owe $2,000, the equity value is $3,000.) Do not count the value of the home you live in or up to two vehicles.

☐ **No, my assets are less than $6,940 (Single) or $10,410 (Married)**

☐ **Yes, my assets are over $6,940 (Single) or $10,410 (Married)** If yes, answer the questions below

What is the value of your assets? _____

Are any of these assets set aside for your final burial expense? ☐ Yes ☐ No

If yes, please tell us how much of your assets are set aside for burial expenses $_____

If you own a pre-need burial contract, please send in a copy of the contract.

APPLICANT AND/OR AUTHORIZED REPRESENTATIVE MUST READ RIGHTS AND RESPONSIBILITIES ON PAGE 3 AND SIGN BELOW

(When possible, both the Applicant and the Authorized Representative should sign.)

Signature of Applicant: _____ Date: _____

Signature of Authorized Representative (AR): _____ Date: _____

Print AR's Name: _____

AR's Address: _____ Main Phone Number: _____

_____ Other Phone Number: _____

Rights and Responsibilities

1. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (888) 808-4238 or writing to the Civil Rights Division, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.

2. I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.

3. I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.

4. I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.

5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:
   - A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
   - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

   I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

6. I know that I must tell SCDHHS within 10 days if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.

7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.

8. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid program, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair hearing. I must submit a written request for such a hearing to SCDHHS. I know that I may represent myself or be represented by someone other than myself.

9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html